STATE WIDE HOSPITAL-SURGICAL PLAN IN VIRGINIA*

The successful experience gained in the North Carolina state-wide hospitalization plan for FSA borrowers gave rise to a desire on the part of FSA personnel in Virginia to develop a similar service plan. County Supervisors, after listening to discussions concerning the merits of multiple county units, canvassed a representative group of their borrower families for the purpose of obtaining their reaction to a state-wide hospitalization and surgical care plan. There was evidence that a large percentage of the active case load would enroll if given an opportunity. Consequently, state and district personnel became tremendously interested in getting something underway.

At the request of the State Director for Virginia, a representative of the Health Services Section in the Regional Office accompanied the Assistant State Director on a visit to the headquarters of each of the five approved Blue Cross hospital service plans in an effort to interest one or more of the executive directors in cooperating with us in the development of a special low cost plan patterned after the North Carolina set-up. All of them were interested; however, in the final analysis, the several boards of directors declined to give special consideration to our group. Perhaps one of the greatest reasons for such declination is the provision in the statute under which these plans operate limiting the area in which any plan may offer service contracts. The largest plan operates in approximately ten counties contiguous to the city in which the primary group is formed. This small area would limit FSA groups in size to such an extent as to make it impractical to attempt the operation of a special plan. The other Blue Cross plans in Virginia operate on a smaller scale. After the failure of our effort to deal with the existing hospital service plans, it was decided that an association of FSA borrowers would be established for the purpose of contracting with hospitals and doctors on a prepayment basis for needed service.

After a tentative hospitalization and surgical care plan was developed, the president of the Medical Society of Virginia was contacted. He was found to be in sympathy with the undertaking and directed us to a special committee in whom the society had vested authority to study and approve service plans affecting the medical profession. This committee is composed of a past president of the society, the president-elect, and the State Commissioner of Health. Approval of the plan was given at a specially called meeting of this group held in Richmond, Virginia. The minutes of this meeting were published in the April issue of the Virginia Medical Monthly. Unreserved approval was reported. In the meantime, county and district supervisors throughout the state were making contacts with individual hospitals and surgeons. Reports from the entire state indicated general acceptance by all concerned.

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It was our desire to work closely with the profession in developing this plan. Therefore, with the assistance of the president of the Medical College of Virginia, certain leaders in the hospital and surgical field were selected to serve on a committee for the purpose of formulating the details of the plan, which included setting a uniform fee schedule for surgical services, and determining a per diem rate for hospitals.

The statutes under which the hospital service plans operate in Virginia was enacted by the State Legislature in 1942 for the primary benefit of such plans. It outlines the procedure by which hospitals and doctors may organize and offer service certificates to subscribers. It places such associations under the jurisdiction of the Securities Division of the Virginia State Corporation Commission. To comply with the provisions of this act, certain annual license fees must be paid, definite contracts must be entered into between the hospitals, doctors, and subscribers, solicitors must pay an annual license fee and certain reserves must be allowed to accumulate. In addition to these features, the Securities Division has authority to limit the area in which the plan may operate in order to forestall competition. These provisions seemed impractical in so far as our plan was concerned. Our Regional Attorney, after careful study of the Act, advised that the provisions contained therein provided for the establishment of an association composed of hospitals and doctors for the purpose of <u>selling</u> services and supplies, but did not provide for the establishment of an association of farmers or others for the purpose of <u>buying</u> services and supplies. The Securities Division of the State Corporation Commission informally concurred in this opinion and advised that the proposed incorporated association of farmers could be organized under the welfare act which did not carry the objectionable restrictions.

In conference with state and district personnel, it was decided that the business of the proposed corporation could best be managed by a small board of directors. The district supervisors were asked to select five men to act as incorporators and serve as the first board of directors.

After the five men, all of whom are FSA borrowers, had been selected, a two day meeting was called in Richmond. The first day, with the assistance of the Regional Attorney, application was made for a charter for the Farmers' Health Association, Incorporated. It was granted, and filed for record. The first meeting of the board of directors was held the second day during which the by-laws, a copy of which is attached, were approved. Likewise, all forms necessary to the operation of the service plan, such as application blanks, certificates of membership, claim blanks, etc., were reviewed and adopted. The State Director was authorized to negotiate for the services of a manager. It was deemed advisable to employ an individual who is experienced in the operation of hospital service plans.

After several prospects were contacted, the Executive Director of Hospital Service Association of Roanoke, Roanoke, Virginia was selected and employed.

Enrollment of FSA borrowers is the responsibility of the county supervisors and selected county membership committees. The supervisors assist the families in completing the application for membership, accept the membership fees and after 40% of the active caseload is enrolled, forward the applications and fees to the Manager of the corporation who issues a membership certificate and an identification card direct to each member. After the initial group is formed, new applications are accepted each month regardless of numbers.

The by-laws provide for the issuance of five different classes of certificates. At present only two classes are being issued, viz: Class B and Class C. Class B provides hospitalization and surgical care for both elective and emergency cases. Class C provides for only emergency hospitalization and surgical care. The Class C certificates are being issued in the eastern section of the state which is the war crowded area. Many hospitals in this area objected strenuously to the complete coverage plan due to the lack of facilities made more acute by the influx of war workers. Therefore, the emergency plan was put in operation in the eastern area of the state as a stopgap and will be discontinued at the first opportunity. Class B certificates provide a maximum of thirty days hospitalization a person per year if needed, for both emergency and elective cases. Five days coverage for ordinary obstetrical cases is included, while complicated cases are eligible for the entire thirty days if necessary. Tuberculosis after diagnosis, nervous and mental cases after diagnosis, treatment of venereal diseases and treatment for alcoholism are excluded. Tonsillectomies and adenoidectomies are limited to most urgent cases. Surgical benefits for all surgical procedures, including fractures, are covered. There is no waiting period for any type of case.

The membership fee for Class B membership is $20 a family per year for services, plus 50¢ a family per year association dues. The twenty dollar fee is tentatively divided as follows: $12 for hospitalization and $8 for surgical care. This division is subject to rearrangement if experience proves it to be inequitable. The 50¢ association dues are used to pay the expenses incurred in organizing the association and pay the expenses of the board of directors. The residue, if any, will be carried as an equalization fund and used at the end of the year if needed. Ten percent of the $20 membership fee is set aside for administrative expense. All fees collected for Class B certificates are maintained in a separate pool.

Class C certificates provide exactly the same coverage as Class B, except that only emergency cases as determined by the attending physician and surgeon are eligible for hospitalization and surgical service. No coverage is provided for ordinary obstetrical cases.

The membership fee for Class C membership is $12 a family per year, plus the 50¢ association dues, and is apportioned as follows: $7 hospitalization, $5 surgical care. This is likewise a tentative division and is subject to change if experience proves it to be inequitable. Ten percent of the $12 membership fee is set aside for administrative expense.

This plan was started with no reserve fund and no assets other than the membership fees collected. Consequently, the hospitals and surgeons are underwriting it to the extent of accepting the payment received as full settlement of bills rendered. The hospitals are paid monthly and the surgeons are paid quarterly. At the end of the year, the accumulated surplus is applied against the accumulated deficit. The board of directors of the corporation will determine the disposition of any net surplus which may accrue from year to year. In the event a net deficit exists at the end of a year, such deficit will be carried forward and paid from surplus funds, if available, the subsequent year. If no surplus exists the subsequent year, the deficit will be written off.

The professional committee set a rate of $4.50 per diem to be paid to hospitals rendering service to Class B certificate holders. This rate is to include a bed in a ward or semi-private room, board, laboratory, operating room, transfusions, X-ray (where furnished by hospital personnel), ordinary drugs and dressings, including casts.

A rate of $4 per diem was allowed hospitals rendering service to Class C certificate holders. This rate is to include all of the services and supplies as outlined above.

The surgical schedule adopted for both Class B and Class C memberships provides a maximum fee of $75 for a major abdominal operation, and ranges downward in keeping with the type of service rendered.

The by-laws make possible the enrollment of all bona-fide farmers regardless of income status. The Corporation's agreement with hospitals and surgeons limits membership to FSA borrowers in view of reduced rates for services rendered. The agreement, however, allows members to continue to participate after they have repaid their loans in full and need no further financing from FSA. If other agencies working with farm people become sufficiently interested, it is possible under the charter to issue another class of certificate which might well provide private room service at a higher membership rate, and a higher scale of fees to hospitals and surgeons.

Since farm people use hospital services less than industrialized groups, a private room certificate can be issued at a lower cost than a comparable certificate covering groups with higher incidence of usage. There is evidence of interest on the part of other agricultural agencies, as well as leading higher income farmers throughout the state. Unless existing hospital service plans become

interested in making a lower cost contract available to farm people, there is likely to be a united effort made to provide needed services through the Farmers' Health Association, Incorporated.

In considering the establishment of these state-wide hospital-surgical service plans in Region IV, much thought has been given to the possible effect on general practitioner care plans. We have continuously stressed the fact that general practitioners' care is the backbone of our service program. Every effort is being made to strengthen these units by building participation and revising agreements with physicians in light of the experience gained from past operations. In North Carolina, where a state-wide hospitalization plan has been in operation for almost one and one-half years, only one general practitioner care unit has been discontinued. Total membership is about the same as a year ago in spite of the tremendous decrease in the number of loans made, as well as the decrease in case-load due to the large number of paid up cases. According to reports from county supervisors, the addition of hospitalization has brought about a vast improvement in our relationship with general practitioners. This is perhaps due partly to the wide publicity given FSA's plan throughout the state and partly because it is now possible to hospitalize obstetrical cases, as well as complicated medical cases, thus effecting a saving of the doctor's time and reducing the cost of his service. Many of the leading general practitioners in both North Carolina and Virginia have expressed a desire to organize general practitioner care plans on a multiple county or state-wide basis. There are many problems in connection with such an undertaking, but with good cooperation from the medical profession, it probably is not an impossible task.